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Chiropractic audits

Allan M Freedman, BA, LLB*

This paper reviews the process which deals with audits of chiropractic billings. It includes the statutory right to review accounts, the factors which lead to a possible audit, the review process itself as well as the possible outcome of a review. Generally, the number of audits performed on professional practices is minimal in relation to the number of practitioners who submit billings for services. Audits are a matter of public necessity involving accountability to the patient and, if government billings are involved, to the public in general. It is incumbent upon the doctor to ensure that proper protocols exist within his or her office to ensure that an audit is nothing more than opening one's office for an inspection which should satisfy all of the concerned parties as to legitimacy of the practitioner's entitlement for reimbursement for services rendered.
(JCCA 2000; 44(2):113–124)

KEY WORDS: chiropractic, audit, practice review.

Le présent article traite du processus de vérification des comptes en chiropratique. Il sera question, entre autres, du droit accordé par la loi de réviser les comptes, des facteurs qui mènent à une éventuelle vérification, de l'examen lui-même et des résultats possible. En général, le nombre de vérifications faites dans le domaine est minimal par rapport au nombre de praticiens et praticiennes qui soumettent des notes d'honoraires pour prestation de services. Les vérifications sont une question de nécessité publique visant la responsabilisation des professionnels à l'égard des patients et, dans les cas où les gouvernements sont partie prenante, à l'égard du public en général. Il incombe aux praticiens et praticiennes de s'assurer qu'un protocole approprié est en vigueur dans leur cabinet, si bien que la vérification ne s'avérera rien d'autre que l'ouverture de ses livres à des fins d'inspection devant satisfaire toutes les parties concernées relativement à la légitimité des réclamations faites pour services rendus.
(JACC 2000; 44(2):113–124)

MOTS CLÉS : chiropratique, vérification, examen de la pratique.

Introduction

Accountability is defined, among other things, as being responsible.[1] It is also defined as being accountable, as in being called upon to account. In the context of a profession, there are a multitude of instances in which accountability comes into play. Such instances include matters relating to standards of care, quality assurance, in some jurisdictions continuing education, and ethical practices. However, just as importantly, the word "accountability" relates to matters of professional fees and the practitioner's rights and obligations as same relate to billings and professional standards.

* Professor, Canadian Memorial Chiropractic College, 1900 Bayview Avenue, Toronto, Ontario, Canada M4G 3E6. (905) 660-0818.

In this paper we will review the mechanism for dealing with audits of chiropractic billings, including the statutory right to review accounts, the factors which may lead to an audit, the matters considered during the review process and the results which may emanate from a review. The actual process of the review which may include a single reviewer, a committee or any other mechanism is not generally of importance in as much as it is the reason for the audit and what is reviewed that is of consequence to the proper performance of a practitioner's professional responsibility. There will be differences in licensing jurisdictions as to how the audit is carried out, but the principles surrounding the audit will generally remain the same. For the most part, the discussion will focus on the Ontario environment, but the reader should not lose sight of the fact that an audit process no matter how commenced, whether statutory or contractual in nature, will generally involve dealing with the same basic principles involving proof of entitlement to compensation based upon accepted standards of practice.

As part of a regulated and licensed profession, a practitioner is given the right to participate in the rendering of services limited to a finite group of individuals. In pursuance of that right, the practitioner is entitled to render a statement of account for such services. Having regard to the fact that services of a professional are not provided within the open market of consumer competitiveness certain obligations are generally placed upon the practitioner to ensure that the public is protected within the scope of professional fees.

Professions, in general, provide mechanisms for dealing with matters of professional billing. The Solicitors Act provides for a means by which a solicitor's account may be reviewed by an Assessment Officer.[2] Regulation 45 of the Architects Act, and Section 29 of the Surveyors Act establish a Fees Committee to deal with professional billings.

Pursuant to the Health Insurance Act ("Act"), medical doctors, chiropractors, dentists and optometrists are entitled to render accounts for services provided to insured individuals. The mechanism for reviewing the accounts of the aforementioned practitioners is the establishment of a Committee, which in the case of chiropractors is titled, the Chiropractic Review Committee ("CRC").[3]

The CRC is structured as a committee of the College of Chiropractors of Ontario (CCO), under the Health Insurance Act, but functions substantially independent of CCO and the Ministry of Health, i.e. at arm's length having regard to the fact that it is created pursuant to OHIP legislation as distinct from that of chiropractic legislation. Its mandate is that solely upon the referral from the General Manager of OHIP to review the OHIP insured accounts of chiropractors pursuant to the authority given it in accordance with the Health Insurance Act of Ontario. The committee, through its process, makes a direction to the General Manager of OHIP to pay all claims, pay some of the claims, or recover all of the claims of the chiropractor during the review period.

It should be noted that while OHIP may deal with the billings of the practitioner to the government funding agency, there is also another mechanism for dealing with complaints of billings by chiropractors, other than OHIP billings, namely a complaint to the licensing body relating to misconduct. Such complaints may be dealt with through the Complaints Committee,[4] or the Quality Assurance Committee.[5] A complaint relating to billings of a practitioner outside of the statutory right to audit may occur because of such matters as the creation of unreasonable contracts for treatments, billings for unnecessary care, and non-disclosure of fees.

Reasons for an audit

There are any number of reasons why a practitioner may be reviewed by a statutory body which include the following, namely:

1 Patient complaints of services not being rendered.
2 Questionnaires being sent to patients who reply that services were not received or patients not remembering that services were rendered.
3 Statistical analysis of a practitioner's practice indicating that the practice is unusual in some manner. OHIP maintains a number of different statistics which may, when reviewed, indicate that the professional practice of the doctor is of a nature which requires it to be reviewed in detail. The following are instances of statistical analysis which might lead to a formal audit, namely:
   a. A higher than average number of new patients in a monthly period.
   b. A higher than average number of x-rays per patient.
   c. A higher than average number of subsequent visits per patient resulting in a higher than average cost per patient ratio.

d. A higher than average number of patients who exhaust their government coverage.
e. A higher than average number of subsequent visits on a daily basis.

There is only one way for a matter to be referred to the CRC and that is by a referral from the General Manager of OHIP. There is no other mechanism for instituting a review of a chiropractor's billings to OHIP which will involve the Chiropractic Review Committee. The referral from OHIP may come as a result of any number of reasons including the following:

1 A complaint from a patient which might deal with the fact that billings were rendered but services were not provided.
2 A complaint from a third party concerning the billing by the practitioner to OHIP. This person might be a disgruntled ex-spouse or ex-employee.
3 A direct request from the OHIP office, based upon the statistical analysis of the practitioner's billings.

The audit process

The prelude

For the most part, the audit process is governed by the Act and the procedures enunciated pursuant to the statute. In addition, certain protocols have been established over the years by the workings of the Committee.

In order to appreciate the audit procedure, the following example of a chiropractic audit being conducted by the CRC is reviewed (using a fictitious name of a chiropractor):

> A memo dated June 16, 1994 is sent from the Profile Officer, Monitoring & Control Provider Services Branch to the Medical Consultant, Monitoring & Control Provider Services Branch of the Ministry of Health. The memo contains the following pertinent information, namely:
>
> The attached profile shows this practitioner sees an unusually large number of patients and Subsequent Services, for most months, are three times the provincial average. Compared with the October 1993 provincial average, for example, the practitioner's billings were as follows:

Practitioner	Patients	Subsequent Visits	Total Treatments	Billings Paid
Dr. John Smith	715	1,489	1,563	13,723
Provincial Average	224	466	510	4,539

> In the preceding 11 months, the number of patients ranged between 686 and 753 and subsequent services from 1,256 to 1,749. Similar billings are noted throughout the period of this review with services totalling 28,359 and payments of $271,681.99 ...
> The practitioner frequently sees well over 100 patients in a single day. For example, on 7 out of the 18 days that billings were submitted in October 1993, the Daily Distribution of Service report indicates more than 100 patients were seen daily:

Date	Patients	Subsequent Treatments	Initial Treatments
October 4, 1993	120	114	6
5	101	99	2
12	111	108	3
14	113	110	3
18	119	114	5
25	111	105	6
28	126	118	8

> ... On October 4 and 28, the number of patients reached a high of 120 and 126 respectively.
>
> Verification statements were mailed to 100 patients asking them to confirm the visits billed on their behalf. All responses indicated agreement.
> In view of the high volume of subsequent services and the number of patients seen daily, it is recommended that John Smith, D.C. be referred to the Chiropractic Review Committee.

As a result of the above mentioned Memo, the General Manager of OHIP forwarded a Memorandum dated September 15, 1994 to the Director, Provider Services Branch, which set out the following, namely:

> The billing pattern of this practitioner is unusual because of the large volume of services. For example, in October 1993

> this practitioner saw 3 times as many patients as the average chiropractor and billed 3 times the average number of claims for subsequent services.
> The daily distribution of services report shows that it is not unusual for this practitioner to see in excess of 100 patients in a single day. For example, in October 1993 there were 7 dates when more than 100 patients were seen.

As a result of this Memorandum in September, 1994, the General Manager of OHIP receives from its Director of Provider Services Branch a memo which is entitled "Request for Referral to the Chiropractic Review Committee": (The referral period, which is the period of time under review, is 18 months in duration):

> The reason for the Referral is set out as follows: "Health Insurance Act, Revised Statutes of Ontario, 1980, Section 18, Subsection (3) a,b,c and d".

The following comment was provided to the General Manager in the example we are reviewing, namely:

> "The billing practice of this chiropractor is unusual because of the high volume of claims for subsequent services. This practitioner frequently sees more than 100 patients in a single day."
> "This referral covers the period from July 1, 1992 through December 31, 1993."

It is imperative that a practitioner understand certain basic precepts of the billing process as they relate to audits, namely first, that section 18(3) requires that a practitioner submitting billings to OHIP be able to establish the following, namely:

1 That the service was rendered
2 That the service was therapeutically necessary
3 That the service was given in accordance with professional standards
4 That the service was not misrepresented.

Secondly, it should be clearly understood that the obligation is upon the practitioner to justify the billing. This situation is analogous to a tax audit. The obligation is upon the taxpayer to prove the deductions being claimed. In the situation at hand, the doctor must be able to justify that the service was rendered, necessary, given in accordance with professional standards, and not misrepresented. There is, for the most part, only one way to establish that the services were rendered, namely the existence of records. If the issue of record keeping leaves any doubt as to its importance in terms of billings the audit procedure will bring home the point that only with the creation and maintaining of proper records can a doctor establish that billings may be justifiable.

The OHIP requirements for justifying billings were further enunciated in amendments made to the Health Insurance Act such that provision 18(2) of the Act provides for the following grounds for refusal to pay for a "service" provided by a practitioner, namely:

> 18.(2) The General Manager may refuse to pay for a service provided by a physician, practitioner or health facility or may pay a reduced amount in the following circumstances:
> 1. If the General Manager is of the opinion that all or part of the insured service was not in fact rendered.
> 2. If the General Manager is of the opinion that the nature of the service is misrepresented, whether deliberately or inadvertently.
> 4. For a service provided by a practitioner, if the General Manager is of the opinion, after consulting with a practitioner who is qualified to provide the same service, that all or part of the service was not therapeutically necessary.
> 6. If the General Manager is of the opinion that all or part of the service was not provided in accordance with accepted professional standards and practice.
> 7. In such other circumstances as may be prescribed.
>
> With respect to paragraph 7, "such other circumstances as may be prescribed", might include a "clawback" for services which might otherwise be paid for.

The investigation

In February, 1995, some 19 months after the first OHIP memorandum is generated, the Practitioner receives his or her first correspondence from the Chiropractic Review Committee.

The following is, for the most part, the correspondence received by the Doctor. You will note that the letter contains much of the information relative to the conducting of the audit process, at the time in question.

February 7, 1995

The Chiropractic Review Committee of the College of Chiropractors of Ontario are informing you that certain of your accounts submitted to OHIP have been referred to the Committee by the General Manager of OHIP.

The General Manager, when concerned about an account, is required by the Health Insurance Act to refer the matter to the Chiropractic Review Committee – a Committee composed of three chiropractors and two public persons. All chiropractors, either acting on the Committee or as an inspector are appointed by the Minister of Health from nominations made by the College. The Committee is divided into two subcommittees, one of which will review your referral.

OHIP was legislated into existence in 1972, and the government understandably wished to have some form of ongoing audit established. The College along with the Ontario Chiropractic Association requested that this be done by a committee of chiropractors rather than a government organized lay tribunal. The Chiropractic Review Committee was, therefore, established under the Health Insurance Act R.S.O. 1990, c:H.6,s.(1). The function of the Committee is to report and make directions to the General Manager on matters referred to it under Section 18 of the Health Insurance Act. The Chiropractic Review Committee in accordance with that section of the Act "may direct to the General Manager that he or she pay or refuse or reduce payment of, or require and recover reimbursement from the practitioner of any overpayment to the amount otherwise payable. ..."

The General Manager of OHIP has questioned your accounts for services rendered during the period July 1, 1992 through December 31, 1993. Enclosed you will find a copy of the General Manger's referral including the support documents.

Pertinent sections of the Health Insurance Act Revised Statutes of Ontario 1990, Chapter 6, Sections 18, 22 to 29 and 37 to 41 are enclosed for your information.

A list of documents, patient files and information to prepare prior to the inspection has also been enclosed.

Generally, the Committee carries out its duties in the following manner:

1) Inspection – An inspector has been assigned for the purpose of interviewing you, inspecting, examining and auditing the books, accounts, reports and case records respecting the patients who have received services for which bills were submitted to the Plan during the review period. Please note the attached list of information to be prepared in advance of the inspection.
2) Inspector's Report – The inspector will ask permission to photocopy on site or remove from the practice approximately 50 to 100 patient records. These will then be photocopied and the originals returned to the practitioner as soon as is practicable. The copied records will then be reviewed by the inspector. The inspector will prepare a confidential report summarizing information from the inspection Section (1) and the clinical records.
3) Committee Review – The Committee receives and reviews the report, charts and photocopies collected of books, accounts, logs and patient records. Should the subcommittee and the full Committee confer with presentation of the case that the billings associated with the care of these patients comply with Section 18, s.s. 3(a)(b)(c)(d) of the Act, a direction would be sent to the General Manager that all claims be paid.

   However, should this initial review by the subcommittee result in concerns that may require reimbursement of money to the Plan, the opportunity of meeting with members of the full Committee will be afforded the member. Copies of all documents will be sent to the practitioner under review, after they have been reviewed by the subcommittee.
4) Interview – If the member is invited to come to such a meeting with the full Committee the intended purpose is to allow him/her to respond to the concerns of the subcommittee. Such a meeting provides the member and the full Committee the opportunity of having all the available information prior to the full Committee reaching a decision, and making its required directions to the General Manager. The member may present whatever representation he/she feels is appropriate to the members of the Committee if he/she does not agree with the report and summary charts.

   The member is offered the opportunity of attending alone or with a lawyer or some other representative or may choose not to attend.
5) Direction – The Committee is empowered to make a range of directions. These may take the form that no reimbursement be sought, or that part or all of the services be refused or reduced in value. Once the Committee has completed its review and written its directions and reasons, the member is informed by the Committee, and by the General Manager of the decision.

For the purpose of proceeding with this review, Dr. Joe Doe, D.C. has been appointed as inspector for the Chiropractic Re-

view Committee pursuant to Sections 37 to 40 of the Act. He will contact you to arrange an inspection at your office at 2 Anywhere Street, Toronto, Ontario in the very near future for the purpose of inspecting your practice as detailed above. Prior to this visit prepare the records from the enclosed list as they will be required by Dr. Joe Doe, D.C. He will also be requesting some additional files, a listing of which will be presented at the time of the inspection. It is important that the inspector/Committee obtain the *complete* records which are requested to avoid any problem which may ensue as a result of missing files.

You should also be aware that the Chiropractic Review Committee has the responsibility to report to the College of Chiropractors of Ontario information that comes to the attention of the Committee in the course of carrying out its duties under the Health Insurance Act respecting a chiropractor's conduct, competence or fitness to practise where the Committee is of the view that it is in the publics' interest for such information to be communicated to the College. The Committee also has the responsibility to make such directions to the College respecting such information as the Committee considers appropriate.

We trust that this review will be courteous, objective, and fair and can be completed with as little inconvenience and disruption as possible to you and your practice. This review is in the nature of an audit, if you have any questions regarding the inspection or the review process please do not hesitate to contact the Administrative Assistant to the Committee at any time. The Committee desires that you understand that no direction concerning the accounts will be made without giving you the opportunity to express your point-of-view in writing or in person. May we thank you in anticipation of your professional co-operation and understanding with this necessary function of the Committee.

Included with the letter from the Chiropractic Review Committee were a number of additional documents which were referred to in the aforementioned correspondence, namely the following: excerpts from the Health Insurance Act; the OHIP referral: OHIP support documents; a list of patient files to prepare; and a list of office books/accounts to prepare – being 56 pages of documentation.

The inspection took place on February 28, 1995 at which time the Inspector attended at the practitioner's office and reviewed the doctor's practice together with 15 patients selected from an OHIP list and 15 patients randomly selected by the Inspector. The Inspector's Report which was forwarded to the CRC was dated March 6, 1995.

The following documentation emanated from the Inspector's meeting with the practitioner, namely:

1 A review of the practice and procedures of the doctor.
2 A photocopy of the files of 15 patients reviewed from the OHIP list.
3 A photocopy of the files of the 15 patients randomly selected by the inspector.
4 A "patient clinical assessment summary form, summarizing the contents of the patient clinical records for 30 patients".
5 A copy of the appointment book for the referral period.
6 A copy of the day sheets for the referral period.
7 A comparison sheet of 629 billed visits versus 629 visits recorded in patient files.
8 A copy of the standard office forms and patient records.
9 A copy of the complete office fee sheets.

It was noted that "sign-in" sheets were not used by the practitioner in his office. As one might imagine, the amount of paper produced for the review required more than 3 six inch binders for collation.

In the example at hand, there was no allegation of fraud, in that no patient suggested that billings had been requested of OHIP when no treatment had been rendered. The question was not whether the service had been rendered or misrepresented. The issue was whether the service was therapeutically necessary and given in accordance with professional standards.

The Inspector's summary was as follows:

This doctor does have a high volume practice. He saw 443 new patients in 1993, according to his records, which averages out to 8.5 new patients per week. He appears to have a large patient base accumulated over ---- years of practice. He does not use any promotional material or advertising but probably attracts many new patients because of not charging above OHIP.

The thirty patient files reviewed had 629 patient visits over the 1½ year period of review. That averages to 20.9 visits per patient or 13.9 visits per patient per year. The provincial average of visits per patient per year, according to the Ontario Ministry of Health printout, page 4, is 27.3. So this doctor does not appear to overtreat patients, his numbers are based on a large volume of patients seen.

This doctor's Patient Clinical Records are adequate in the consultation area. They are not, however, up to the required

standards in the examination and plan of management areas. Progress notes are good on the side of daily subjective comments but are lacking in the objective and re-examination areas primarily due to the lack of initial examination findings that can be re-measured to gauge the patient's progress from an objective perspective.

The Inspector's conclusion was as follows:

This practitioner's compliance with the provisions of Subsection 18 (3)(a), (b), (c), and (d), of the Health Insurance Act is as follows:

a) The records viewed indicate that all of the insured services were rendered.
b) The lack of examination records does call into question whether services were therapeutically necessary. However the consultation records and progress note comments of improving symptoms do suggest that services were therapeutically necessary .
c) Apart from the lack of recorded examination findings it appears that services were provided in accordance with accepted professional standards and practices.
d) There does not appear to be any misrepresentation of the nature of the services rendered.

In furtherance of the Inspector's Report, a Notice of Interview was forwarded to the Practitioner dated July 25, 1995. The correspondence reads as follows:

NOTICE OF INTERVIEW

The Chiropractic Review Committee wishes to thank you for the courtesy you extended Dr. John Doe, D.C. at the time of the visit to your practice. The required report has now been submitted which the Committee has reviewed in a preliminary way, and a copy is enclosed for your information. Copies of the referral letter from the General Manager of OHIP, plus attachments have already been supplied to you. The computerized month by month patient billing summaries or the microfilm copies of OHIP claim cards (if present) are not reproduced, and if desired, may be examined at the offices of the Chiropractic Review Committee by appointment between the hours of 10:00 a.m. and 3:00 p.m. Tuesdays and Thursdays.

Having reviewed this material, the Committee invites you to meet with the full Committee on an informal basis without testimony under oath, nor the presence of a court reporter. The purpose of this interview is to discuss the following matters regarding your accounts, for the period dated July 1, 1992 through December 31, 1993 that the General Manager has referred to the Committee:

Services	Code	Concern
Subsequent Visits	V-101	Therapeutic Necessity Professional Standards The higher than average volume of claims for subsequent services, V101.

Up to three and one-half hours have been set aside commencing at 10:00 a.m. on Tuesday, September 12, 1995 for your meeting with the Committee. If you are unable to attend at that time, would you please inform our office as soon as possible in order that another date and time might be arranged.

This meeting is part of the information gathering process to enable the Chiropractic Review Committee to make its required direction to the General Manager concerning the accounts, in that all or part of the accounts be paid as submitted, or be reduced in amount, or refused for payment.

The General Manager is usually required to carry out the directions of the Committee.

You may, of course, bring with you any advisor(s) you feel might be helpful. You may, if you wish, seek the advice of your colleagues. You may also wish to consult/retain a lawyer. Please know that although note taking is permitted, the Committee will have its Administrative Assistant present to assist in the recording of the proceedings in general.

The interview format is designed to allow you and the Committee the opportunity to review and discuss informally the relevant elements of your practice and documentation. Thus, the members will wish to examine a number of patient's charts or office records relevant to the concerns. Particulars as to which charts or records will be required will be forwarded to you at a later date.

The Investigative Committee is also interested in receiving your comments, if any, on the Inspectors' Report. In order, however to be able to spend as much time as possible at the interview reviewing and discussing your charts, you are invited to submit your comments, explanations or representations relating to the Report in writing as soon as possible and, in any event at least three weeks in advance of the interview. Your written response

will then be available to the Committee prior to the interview, and will be taken into account prior to any direction being made. You are, of course, welcome to make any additional remarks regarding the Inspector's Report to the Committee at the time of the interview. It is hoped, however, that most of your comments will be made, in writing, before the meeting so that the maximum time may be allocated to reviewing your patient charts, and to having useful discussions with you in regard to questions arising from that review. Your attention is also drawn to the CRC Bulletin Vol. 1, No.l 9 dated February 28, 1984 with respect to Record Keeping.

The interview

The hearing is quasi-formal in nature, in that the setting involves a structured environment in which the Committee is divided into two parts, namely two members who were part of the Investigation, and the remaining three members who comprised the "hearing committee". The full Committee is made up of five individuals, three of whom are chiropractors and the remaining two members are public members who are not members of a regulated health profession. In addition, to the members of the Committee, the inspector is in attendance together with the Administrative Assistant to the Committee and the Legal Counsel to the CRC.

The Chair of the Committee commences the interview by explaining the process and introducing the parties. The practitioner is then entitled to make any statement, and thereafter the members of the inspection team proceed through the Inspector's report and the files of the practitioner.

The focus of the Interview involves dealing with the concerns of the General Manager of OHIP as outlined in the referral letter. The Inspector's report is dealt with in detail and the files of the practitioner are examined in the context of the concerns as aforesaid.

As part of the Inspector's report, a review of the files is carried out for the purposes of completing a profile of a patient vis a vis the patient chart. The information as it relates to an initial examination and a subsequent examination is generally fundamental to the general principles of record keeping.

It is not within the purview of this article to determine what the standard of practice of chiropractic might be in any particular jurisdiction. The issue of whether a patient's care should include a determination of subjective and/or objective symptomatology on each visit; what terminology should be used to ascertain a diagnosis/assessment; what information should be included in a plan of management; when a reassessment should take place are all issues which are the subject matters which will be reviewed by the Committee. It must be understood that the overriding issues involve therapeutic necessity of care and care given in accordance with professional standards. Within this context, it is incumbent upon the practitioner to prove that the information maintained in the records constitute proof that care was given and that it took place within the standards of the profession.

However, from where are the standards that are applied by the Committee derived? Having regard to the fact that the profession of chiropractic is legislated, the requirements for maintaining professional records and the providing of treatment should first and foremost be found within the statutes, regulations and policies of the licensing board. This is not to say that the third party payer, in this case OHIP, might be prohibited from establishing criteria for entitlement to payment. Quite the opposite is true. For example, notwithstanding that a practitioner may give reasonable and necessary care to a patient through a telephone consultation, or a screening process for employment neither of these instances will allow for billing to OHIP.

The issue becomes whether an audit committee should be in a position to establish policies and criteria for entitlement to reimbursement for services from any third party payor or alternatively whether the committee should be restricted solely to carrying out the policies and guidelines of the statutory body governing the profession. Put another way, can the committee determine what constitutes the standards of practice of chiropractic or can it merely apply the standards of the profession to the particular cases which it is reviewing?

The mechanisms for establishing standards of practice in chiropractic are numerous, namely, the licensing board, the professional associations, educational institutions and the courts.[6] There are additional factors which will establish a standard of professional care, i.e. Specialization, advertisement, and representations.[7] There is no known mechanism for establishing authority for a committee to create standards of practice as compared to applying the standards which are created by those organizations who

are generally provided the authority to establish such standards.

It should be noted that the CRC was established by statute, from the outset of the allowance for reimbursement for chiropractic care through OHIP. In addition, from 1972 when OHIP was first established with respect to the practice of chiropractic in Ontario, the profession had been firmly established by legislation. It was and remains incumbent upon the regulatory board to establish the guidelines governing the standards of practice of chiropractic within the Province of Ontario.

> During the hearing the practitioner was invited to review his files with the committee. Explanations were requested concerning the initial examination of the patient, the diagnosis, the plan of management, the continuing care, and the reassessment of the patients. After approximately 3 hours the interview was concluded. Some two months later, a draft of the direction which was prepared by the Committee for the General Manager of OHIP was provided to the member for review and comment.

After the Committee receives any comments which the member may wish to make, it considers the comments and thereafter will provide its direction to the General Manager.

Appendix A represents data collected from an Application made pursuant to the Freedom of Information Act of the Province of Ontario relating to referrals which have been made to the Chiropractic Review Committee.

> The interview with the Chiropractic Review Committee took place in September of 1995. In November of 1995 a Preliminary Direction of the Chiropractic Review Committee was forwarded to the Practitioner for his comments. After correspondence was forwarded on behalf of the Doctor to the Committee a Final Direction was made by the Committee to the General Manager in December of 1995. The Decision of the General Manager, based upon the direction of the Committee was rendered in February, of 1996 and forwarded to the Practitioner in April of 1996. Within the prescribed time (being 15 days) an appeal was filed with the Health Services Appeal Board to appeal the Decision of the General Manager. The Appeal Documentation was filed in June of 1996. The matter was subsequently settled and the Appeal was withdrawn in April of 1997. The matters giving rise to this review first arose in July of 1992 and the interview took place in 1995 with the matter disposed of in 1997.

While the matter was concluded by the Chiropractic Review Committee, its mandate, in accordance with the legislative requirements governing the Chiropractic Review Committee, required that a decision of the General Manager be communicated to the College of Chiropractors of Ontario. In this Audit, the Decision was provided to the College. The matter was then referred to the Complaints Committee which dealt with the matter as one involving a concern about record keeping.

> It was the decision of the Complaints Committee that the Doctor "attend for a record-keeping course and provide proof of successful completion of the course within six months of receipt of their request followed by a random file audit at a future date after completion of the course". The Doctor did not object to the decision of the Committee. As indicated, the matter came to a complete resolution in 1997.

Additional considerations

It is important that OHIP or any government or third party payer for health care be regarded as a matter of a public issue. In many ways, unlike the HMO's in existence within the United States, health care payments in Canada are based upon "self-governance", that is, a practitioner provides the care and submits the account for services. If required, the practitioner must then prove entitlement to the funds. In a HMO setting, the practitioner may have to deal with what has been referred to in the health care industry as a "gate keeper" who will decide whether the care will be authorized prior to it being provided to the patient. Our system is based upon the trust associated with ensuring that there is responsibility in rendering accounts for services.

In addition to the audit which may be performed by a billing agency who may be required to reimburse the practitioner or patient for the services provided to the patient, there is also the possibility that a practitioner may be accountable for his or her conduct to the licensing board or through criminal proceedings. In the case which was examined, the matter was, as required, referred to the licensing board. If the board had determined that there had been improper conduct beyond that of a record keeping issue, ie. Billing for missed appointments, billing for non-existent treatments, etc., the actions of the licensing board may

have been much more dramatic and serious in nature. Such administrative proceedings by the licencing boards does not preclude the laying of criminal charges for matters relating to fraud and/or misrepresentation.

There are a multitude of statutes, regulations, policies and guidelines which govern the profession of chiropractic in so far as they relate to the matter of the rendering of services, reimbursement for such services and the accountability relating thereto. Such issues may include matters relating to treatment of patients in the following scenarios, namely:

treatment of patients who are members of health clubs,
treatment of patients who are members of athletic teams,
treatment of patients who are residents in nursing homes,
defining what constitutes a house call
using two-tiered billing.

Whatever jurisdiction the practitioner resides in, it is imperative that he or she remain current in their knowledge of the professional requirements of what is required for the purposes of billing for patient care and the documentation necessary to substantiate the billings which have been submitted for the care rendered to a patient.

Conclusions

One might conclude that the auditing of a chiropractor's practice must necessarily result in a reimbursement to the billing agency. Such a conclusion would be erroneous. The process is a necessary by-product of the billing process. As indicated, a professional practice customarily involves self-governance. The number of audits performed on professional practices is minimal in relation to the number of practitioners who submit billings for such services.

Without the establishment of a Committee such as the Chiropractic Review Committee in the Province of Ontario or a similar committee in any other jurisdiction, the matter of a review of billings would be left to another venue which may be comprised of individuals without the background needed to appreciate the standards involved in the practice of the profession. For the purposes of ascertaining whether there has been compliance with billing requirements, the overall principle must involve compliance with professional standards. This will logically result in a review of the practitioner's practice to determine that there has been minimal requirements met for record keeping and the rendering of professional services. For example, records must contain more than a date stamp and ditto marks. In addition, it would be difficult to substantiate a treatment regime involving 150 treatments over an eighteen month period for a particular patient without a referral to another chiropractor or other health care practitioner to determine why the care was not resulting in a change in the patient's state of health or more importantly whether the care was necessary and being given in accordance with professional standards. It may well be that 150 treatments within an eighteen month period is necessary but the onus will be upon the practitioner to prove, through records, that the care is appropriate. While the matter of "record keeping" is an integral part of an audit, it is only one component of the audit process.

Understandably, the thought of an "audit" raises concerns with a practitioner. However, if all is well with the practitioner's practice in terms, for the most part, of record keeping and billing practices then the matter of the audit should be routine. Audits are a matter of public necessity involving accountability to the patient and, if government billing is involved, to the public in general. It is incumbent upon the Doctor to ensure that proper protocols exist within his or her office to ensure that an audit is nothing more than opening one's office for an inspection which should satisfy all of the concerned parties as to the legitimacy of the practitioner's entitlement for reimbursement for services rendered.

As a final comment, and disclaimer, it is imperative that the reader appreciate the importance of reviewing the professional requirements relating to patient billing in any particular jurisdiction. While the policies governing audits, in general, and the importance of the process are generic in nature, the references contained in this paper may be limited to the Ontario jurisdiction, and even then, may be amended from time to time by changes in legislation and policy. As an example of the ongoing amendments to the audit process are the recent changes in audit legislation in Ontario which allow for cost recovery by OHIP from the practitioner in those situations where cost recovery is allowable. As such, readers are cautioned and referred to the legislation of the jurisdiction in which they practice, including Ontario, to ensure proper compliance by the practitioner with the obligations associated to patient and third party billings.

References

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4 Regulated Health Professions Act, R.S.O. c.R. 18, Schedule 2, section 25.
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Appendix "A"

The following data relates to recommendations from CRC to the General Manager of OHIP which recommendations resulted in a reimbursement by a practitioner to OHIP. Out of 163 interviews, in 48 instances there was a recommendation to pay all claims (33) or the matter was still pending (15). The amount of reimbursement ranged from $500.00 to $82,119.96. The information set out below deals with general categories for referrals and provides examples of the reimbursement amounts relating to the general categories. In most cases, there are multiple reasons raised for a referral of the chiropractor's practice to the CRC , ie. Record keeping, billing of uninsured services, billings rendered without services having been provided, etc.

TOTAL NUMBER OF REFERRALS	VARIOUS REASONS FOR REFERRALS	REIMBURSEMENT AMOUNTS	Year in which Recommendation took place
approximately163 interviews			
	OHIP and WCB billings for same patient	$15,803.01	1992
	Uninsured Services, i.e.	$9,878.88	1995
	Orthotics Naturopathic Care	$23,913.87	1977
	Inadequate Records	$13,704.16	1997
		$9,114.81	1990
		$82,119.96	1990
		$35,446.75	1997
		$10,000.00	1997
		$20,000.00	1992
		$36,662.24	1995
		$34,375.13	1997

TOTAL NUMBER OF REFERRALS	VARIOUS REASONS FOR REFERRALS	REIMBURSEMENT AMOUNTS	Year in which Recommendation took place
	High Volume and X-rays	$18,133.05	1982
		$7,534.93	1981
		$16,294.50	1976
		$12,341.52	1985
		$41,771.94	1982
		$10,000.00	1983
		$30,057.40	1994
		$16,692.00	1976
		$13,048.81	1996
	Billed not rendered	$6,738.48	1991
		$39,548.00	1988
		$8,944.57	1990
		$10,661.35	1989
		$14,072.00	1980
		$19,639.73	1992
		$16,779.80	1976
		$58,422.37	1995
		$16,009.96	1992
	Billing for initial and subsequent visits for the same visit	$8,000.00	1990
		$40,937.87	1982
		$16,548.06	1990
		$8,915.15	1981
		$14,358.03	1987
		$4,549.96	1997
		$4,443.75	1987
	X-ray deficiencies	$58,041.48	1980
		$7,326.60	1978
		$14,987.52	1988
	Improper billing of home visits	$13,000.00	1995
	Billing for services not rendered and record keeping deficiencies	$36,662.24	1995